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	295079	A. BUILDING _____ B. WING _____	02/12/2009

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on 2/9/09 through 2/12/09. The census at the time of the survey was 126. The sample size was 30 and included three closed records. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 222 SS=B	483.13(a) CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review, the facility failed to ensure that the resident or their legal representative made an informed choice about the risks and benefits of chemical restraints for 6 of 30 residents (#1, #2, #3, #11, #17, and #20). Findings include: Review of the facility's Psychotropic Medications	F 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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policy and procedure revealed that antipsychotic, antidepressant, antianxiety and sedative/hypnotic medications were identified as psychotropic medications. The procedures included behavior evaluations and ongoing behavior monitoring.

An interview with the facility's Minimum Data Set (MDS) Coordinator and a social worker, confirmed that it was the facility's policy and procedure to obtain consents for psychotropic medications.

Resident #1 was admitted to the facility on 11/8/08, with diagnoses including Alzheimer's dementia, history of chronic obstructive pulmonary disease and stage III left lung cancer. Medication orders included the psychotropic and antianxiety medications of Haldol 0.5 milligrams (mg) which was to be given with Ativan 0.5 mg as needed for increased agitation and anxiety.

Review of Resident #1's Medication Administration Records revealed that the Haldol and Ativan had been administered five times in November 2008, three times in December 2008, and one time in January 2009. Review of the medical record failed to reveal evidence of signed consent forms for the Haldol and Ativan.

On the afternoon of 2/9/09, an interview with the Assistant Director of Nursing, a registered nurse, the SW, and the MDS Coordinator confirmed that Resident #1 did not have consents for the Haldol and Ativan.

Resident #2 was admitted to the facility on 8/18/08, with diagnoses including Parkinson's disease, acute renal failure, behavior problems, mental disorder and depression psychosis.

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Medication orders included Ativan, an antianxiety agent, 0.5 mg three times a day as needed for agitation.

Review of Resident #2's medical record failed to reveal evidence of a consent for the Ativan.

An interview on 2/11/09, with two licensed practical nurses (LPN) confirmed that Resident #2's medical record did not have evidence of a consent for the Ativan. The Medical Records Coordinator #1 also confirmed that there was not a consent for the Ativan in the medical record.

Resident #11 was admitted to the facility on 6/11/08 with diagnoses of Alzheimer's disease, seizure disorder and thyroid disease. Medication orders included the antianxiety agent Ativan 0.5 mg to be given at bedtime for nervousness.

Review of Resident #11's medical record failed to reveal evidence of a consent for the Ativan.

An interview with an LPN confirmed that Resident #11's record did not have a consent for the Ativan.

Resident #17 was admitted to the facility on 10/23/08, with diagnoses of closed head injury, history of alcoholism, psychosis, hallucinations, altered mental status, and dementia. Medications included the psychotropic and antianxiety medications of Ativan 0.5 mg which was to be given with Haldol 0.5 mg every four hours as needed for anxiety/agitation.

Review of Resident #17's medical records failed to reveal evidence of a consent for the Ativan and Haldol. Review of the record revealed that

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behavior monitoring as outlined in the facility policy was not being completed.

On the morning of 2/12/09, an interview with the SW confirmed that behavior monitoring was not completed and that there were no consents for the Ativan and Haldol for Resident #17.

Resident #20 was admitted to the facility on 6/23/08, with diagnoses of dementia, renal failure, dysphagia, and history of a cerebrovascular accident. Medications included Ativan 1.0 mg to be given once a day for agitation and as needed every eight hours for anger/outbursts.

Review of Resident #20's medical record failed to reveal evidence of a consent for the Ativan. The SW confirmed that there was no consent for the Ativan.

Resident #3 was admitted to the facility on 8/20/07, with diagnoses that included senile psychosis, Alzheimer's disease, and dementia with behaviors.

Review of the physician's orders for Resident #3 revealed an order written on 11/21/08 for Depakote 250 milligrams (mg) for "hitting." An order for a psychiatric consult was written on 12/1/08 for "yelling out, cursing, and pushing resident." The resident had received Depakote twice a day since 11/21/08.

Review of the consents for Resident #3 failed to reveal a consent for Depakote. Interview with a SW confirmed that there was no consent for the Depakote. She stated that it was the facility policy to obtain consent for psychotropic medications prior to beginning the medication.

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F 258 SS=B	483.15(h)(7) ENVIRONMENT- SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to maintain comfortable sound levels. Findings include: On 2/10/09 at 2:30 PM, a group interview was conducted. Four residents complained of excessive noise during the night, especially around 2:00 AM. The comments were: "Those barrels! The wheels make so much noise. Have you heard them?" "When they fill the water pitchers, the ice scoop in the ice makes so much noise. Why do they have to do that at 2:00 AM?" The four residents lived on either the 100 hall or the 200 hall rooms located outside the secured 200 hall. On 2/11/09 at 2:45 PM, Resident #28 was interviewed. She stated that at night it can be very noisy. She said the rolling barrels have very noisy wheels, and that the noise usually seemed to be around 2:00 AM. She stated that she sleeps with her door closed, but that she is still awakened by the noise. On 2/10/09 at 8:15 PM, an observation was done. Two certified nursing assistants were observed wheeling the trash and linen barrels down the 100 hall. The wheels on the barrels were observed to be noisy.	F 258		
F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS	F 281		

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The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and policy review, the facility failed to meet the medication and/or assessment needs for 2 of 30 residents. (#12,#14)

Findings include:

Resident #12 was admitted to the facility on 7/2/08, with diagnosis including panic disorder, congestive heart failure, hypertension, depressive disorder, obesity and chronic obstructive pulmonary disorder.

On 2/10/09 at 9:00 AM, during the medication pass, Resident #12 approached the registered nurse (RN) to request a breathing treatment for her shortness of breath. The RN stated that she would bring the treatment to the resident's room shortly. At 9:30 AM, the RN discovered the scheduled medication was not available in the medication cart stating "we must have run out" and went to the resident's room to inform her. On arrival to the resident's room it was observed that the resident was sitting in her wheelchair with her nebulizer in her hand waiting for her breathing treatment. The RN explained to the resident that the medication was not available and that she would "track it down." The RN then left the resident's room.

RN #2 did not assess Resident #12 for dyspnea (shortness of breath) per professional standards

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and left her alone to locate the medication. The RN was unable to locate the Director of Nurses (DON) for guidance and received assistance from the Advanced Practice Nurse (APN). The APN stated she would call the physician to get an order for an alternative medication that could be given to the resident immediately.

At 9:45 AM the physician had not responded and the RN had not been back to check on Resident #12's respiratory status.

At 9:50 AM the DON was interviewed. She said the medication would be in the facility's "SureMed" which was their backup supply of certain medications for emergency use. A licensed practical nurse (LPN) retrieved the medication from the "SureMed" and administered the breathing treatment to Resident #12 at 10:00 AM, one hour after the resident requested the medication for her respiratory distress.

An interview was conducted with the RN on 2/10/09 at 10:30 AM. She stated that she should have stayed with Resident #12 and assessed her respiratory status and called for assistance with locating the medication.

Resident #14 was admitted to the facility on 9/17/08, with a diagnoses of cerebrovascular accident with altered mentation and mild right hemiparesis, acute dehydration, severe dysphagia with gastric tube, diabetes mellitus, and hypertension.

Record review revealed Resident #14 had a order for a Duragesic Patch 12 micrograms every 72 hours. Review of the Medication Administration Record (MAR) revealed the medication was

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F 281	Continued From page 7 unavailable on 2/11/09 at the 8:00 AM administration time. The medication was circled as "not given" on the MAR due to unavailability. The record revealed the physician was notified and the medication was ordered from the pharmacy that day. Review of the narcotic count sheet revealed the medication was received the afternoon of 2/11/09. Review of the MAR revealed three nursing shifts (8 hours each) had failed to identify that the medication was available and not given. On 2/12/09 at 11:00 AM, an interview was conducted with an RN. She stated the medication was received in the afternoon on 2/11/09, but was never given to Resident #14. An interview with the DON was conducted on 2/12/08. She stated that, if the nurse going off shift did not report a medication was unavailable during her shift, the oncoming nurse has no way of knowing that. She stated "the nurse should have passed that information on in report."	F 281		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and chart review, the facility failed to provide the necessary activities of daily living for personal hygiene needs for residents with paralysis and contractures for 3	F 312		

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of 30 residents (#6, #26 and #27).

Findings include:

Resident #6 was admitted to the facility on 1/14/08, with diagnoses which included cerebral vascular accident with dysphagia and left sided paralysis, depression, peripheral vascular disease and morbid obesity. Resident #6 was alert and oriented and able to make her own choices and her needs known.

On 2/10/09 at 2:00 PM, an observation of a full skin assessment by a registered nurse (RN) and a certified nursing assistant (CNA) was conducted. The resident's left hand was edematous and severely contracted. The RN did not assess the resident's hand until it was brought to her attention by the surveyor. The assessment of the contracted left hand revealed the resident's fingernails were 1/2 inch long and beginning to dig into the skin on the palm of the hand. The skin on the palm was macerated with a large amount of foul smelling white exudate. Resident #6 stated it was painful to have the hand opened even a small amount, but was compliant and understood the need for the the assessment.

On 2/10/09 at 3:00 PM, an interview was conducted with the RN. She stated Resident #6 "frequently will not let us touch her left hand because it is painful."

Review of the Minimum Data Set revealed under activities of daily living (Self Performance) revealed that Resident #6 was totally dependent for personal hygiene needs. A care plan indicating assistance with activities of daily living could not

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F 312	Continued From page 9 be located in the medical record. Resident #26 was admitted to the facility on 7/8/02 with diagnoses including diabetes, joint contracture and dysphagia. Her MDS dated 1/10/09, revealed that she had severe cognitive impairment and was totally dependent on staff for her grooming needs. On 2/12/09 at approximately 11:00 AM, Resident #26 was observed sitting in the hallway of the 100 unit. The resident's hands were contracted and her fingernails were long approximately 1/2 inch in length. Her fingernails, with the exception of her thumbs, dug into the palms of her hands. The nails on both her thumbs and index fingers were jagged. On 2/12/09, an RN was interviewed. She reported that the CNAs were supposed to cut the residents' nails on their shower day. She agreed that Resident #26's nails were long, jagged and in need of trimming. The nurse trimmed the resident's nails. Resident #27 was admitted to the facility on 4/26/02, with diagnoses including vascular dementia, congestive heart failure and joint contracture. Her MDS dated 12/29/09, revealed she had severe cognitive impairment and was totally dependent on staff for grooming needs. On 2/12/09 at approximately 10:45 AM, Resident #27 was observed in her room. Both of her hands were contracted. Her nails on both of her hands were long approximately 1/4 inch in length. Her fingernails, with the exception of her thumbs, dug into her palms. Her right index finger nail was jagged.	F 312		

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F 312	Continued From page 10 On 2/12/09, a CNA was interviewed. She reported that Resident #27's nails were supposed to be cut on shower days. She examined the resident's nails and said she would cut them. The DON was asked for the facility policy addressing nail care, but did not submit the policy prior to the conclusion of the survey. She confirmed that the facility practice was to cut the residents' nails on shower day.	F 312		
F 364 SS=B	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and measurement of food temperatures, the facility did not ensure that food was served at the proper temperature. Findings include: On 2/9/09 at 7:00 AM, it was observed that bowls of oatmeal with lids had been placed on the trayline counter to be assembled with the breakfast trays. The temperature of the oatmeal was 118 degrees Fahrenheit (F). Food temperatures which had been recorded that morning in a log book indicated the oatmeal was 176 degrees F. The cook reported that she took the temperature of the oatmeal at 6:30 AM. The Dietary Manager stated that the kitchen's policy was to check trayline food temperatures just prior	F 364		

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to meal service. He indicated that the bowls of oatmeal had been prepared too early.

During the group interview on 2/10/09, two residents stated that hot food was sometimes served cooler than desired in the dining room. On 2/9/09 at approximately 12:25 PM, lunch service in the assisted dining room was observed. The Certified Nurse Assistants (CNAs) removed the tray lids covering the food as they served the meal to each resident. The food served was a hot dish and the removal of the tray lid allowed the food to cool.

Residents #26 and #29 waited for ten minutes with their trays uncovered before they were fed by staff. Resident #30 waited for 13 minutes with his tray uncovered before he was fed by a staff member. All three residents were unable to feed themselves.

A pureed test tray was ordered on 2/10/09. The tray lid was removed when the last resident was served and food temperatures were taken after ten minutes. The temperature of the meat was 110 degrees F. The vegetable was 112 degrees F. Another test tray was ordered on 2/11/09 during the morning meal. The tray lid was removed for 10 minutes after the last resident was served his meal. The oatmeal was 120 degrees F and the eggs were 120 degrees F. The desired temperature for all foods tested on the test tray was equal or greater than 140 degrees F.

On 2/12/09, the Dietary Manager was interviewed and confirmed that the tray lids should not have been removed until a CNA was ready to feed the residents. The Director of Nurses was also

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F 364	Continued From page 12 interviewed and confirmed that the lids should have remained on the plate to maintain the proper temperature.	F 364		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, the facility did not ensure that food was stored and distributed under sanitary conditions. Findings include: Improper food dating: A tour of the kitchen on 2/9/09 at 8:30 AM, revealed that foods which had been prepared or opened had been dated with an expiration date, but not with the required date of opening or preparation. The Dietary Manager stated he had implemented this new form of food dating two weeks ago, with the intent of making it easier for kitchen staff to know when to discard the food items. He reported he had recently conducted an in-service with staff on how to determine expiration dates for various foods. The manager reported he was not aware of the regulation to date foods when prepared or opened. The facility did not have a written policy regarding the dating and discarding of food.	F 371		

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F 371	Continued From page 13 Potentially hazardous foods: On 2/10/09 at Station 2, it was observed that a snack tray, which included cheese sandwiches, jello, a cup of melon, cookies, and bananas, was left on top of the refrigerator for 45 minutes. On 2/12/09 at 10:15 AM, a snack tray was delivered by the kitchen staff to Station 2. An Activities worker took the tray to the activities room and began distributing the snacks to the residents. She was observed giving cookies to residents with bare hands. The employee reported that the usual procedure was for the snack tray to be left on the table for an hour and a half during the activities period. Upon being interviewed, the Dietary Manager stated that other kinds of sandwiches, including meat sandwiches, were sometimes added for snacks. He further reported that the facility's acceptable practice was for potentially hazardous snacks to be refrigerated right away if not immediately consumed by residents. There was no written policy outlining this practice of keeping potentially hazardous foods refrigerated at the activity areas. Outdated foods: On 2/11/09 at 2:30 PM at Station 2, bowls of pudding dated 2/9/09 were observed on a tray on the top of the refrigerator. The Dietary Manager stated that the kitchen's policy was that the pudding, for use with medication pass, was to be discarded by the following day. A licensed practical nurse stated, "Nurses are supposed to discard anything opened or left out of the refrigerator at the end of our shift." There were no written procedures pertaining to the protocol for discarding outdated foods at the nursing stations.	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES	F 431		

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	295079	A. BUILDING _____ B. WING _____	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN MOUNTAINVIEW HEALTH	201 KOONTZ LANE CARSON CITY, NV 89701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy review the facility failed to properly label medications with the date they were opened,	F 431		

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ensure safe and proper storing of drugs and biological, and to dispose of outdated medications.

Findings include:

Review of the facility's Storing Drugs policy and procedures identified the following:

Drugs and biological will be stored in a safe, secure and orderly manner, at proper temperatures.

Drugs requiring storage in "a cool place" must be stored in a refrigerator designated for medications.

Refrigerated drugs must be stored in closed, labeled, separate containers.

All drug storage areas must be kept clean, well lit and free of clutter at all times.

Review of the facility's Medication Expiration policy and procedure identified the following:

"Date Opened" stickers would be used.

Multiple dose injectables containing preservative (including insulin) would expire 30 days after opening and all such container were to include a date opened sticker.

That when a container was opened, the nurse opening the container is responsible for writing in the date opened on the sticker.

That any pharmacist or nurse may declare a product unfit for use at any time regardless of expiration date, if there were reason to believe that the preparation was no longer sterile, otherwise contaminated, decomposed or sub-potent.

On 2/10/09 at approximately 9:30 AM, an observation of the medication cart for Station III was made. The following was found:

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F 431	Continued From page 16 A bottle of prescription Nitro Quick that had expired 12/2008. A house stock bottle of Vitamin B-1 that had expired 1/2009. A house stock bottle of Bisacodyl that had expired 12/2008. A house stock bottle of Loperamide anti-diarrheal that was opened and not dated. A house stock bottle of Geri-Dryl Allergy Relief that was opened and not dated. Approximately five-six Compazine suppositories were unrefrigerated. Three pink tablets that were not packaged, not identifiable lying loose in the drawer. Two yellow tablets that were not packaged, not identifiable lying loose in the drawer. One peach tablet that was not packaged, not identifiable lying loose in the drawer. One white tablet that was not packaged, not identifiable lying loose in the drawer. Several drawers had a powder residue and bits of tablets, and needed to be cleaned. A licensed practical nurse (LPN) was interviewed at approximately 10:30 AM. The LPN acknowledged that suppositories should be refrigerated, but stated she liked to keep them at room temperature on the cart because they were easier to administer. The LPN stated she was not preparing to administer any suppositories at the time. On 2/10/09 at approximately 10:40 AM, an observation of the medication room for Station II was made. The following was found: Three medium sized boxes full of resident unit dose packaged return medications dated December 2008 and January 2009; one box was stored on the floor, the remaining two boxes were	F 431		

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on the counter top taking up a majority of the work space.

A vial of Novolin R that was opened and not dated.

Throat lozenges were stored next to Fleets Enema.

Sterile transparent dressing that had expired 9/2003.

Sterile intervenous catheter that had expired 5/2003.

Three culture swab collections tubes that had expired 10/2008.

Approximately 24 sterile culture swabs that had expired 3/2007.

Approximately 25 Urinalysis collection tubes that had expired 5/2008.

Four BD Vacutainers used for blood collection that had expired 3/2008.

Three BD Vacutainers used for blood collection that had expired 9/2006.

Eighteen BD Vacutainers used for blood collection that had expired 10/2006.

Two BD Vacutainers that were unwrapped found loosely in drawer.

The area under the med room sink was grossly soiled with an unidentified yellow substance that was dried and crusty.

In an interview with the Director of Nursing (DON), the DON confirmed the return medications observed on Station II should have been destroyed and that the area under the medication room sink was soiled.

On 2/10/09 at 1:30 PM an inspection of the Medication Cart 1B was done. The following was found:

A bottle of buffered Asprin with an expiration

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F 431	Continued From page 18 date 1/09 Two unidentified medication cups with one pill in each cup was found in the top drawer of the cart. On 2/10/09 at 2:30 PM an inspection of the medication room on Unit 1 was completed. The following was found in the medication refrigerator: Seven house stock Aspirin suppositories with an expiration date 9/07. A resident's Cephalexin suspension 250 mg/5 ml with an expiration date 11/29/08. On 2/10/09 at 3:00 PM an interview was conducted with an LPN. She stated the expired medications should have been removed from circulation and destroyed per facility policy at the time they expired. On 2/11/09 at 11:40 AM, an observation was done in the Station 3 medication room. The following was observed: Two tubes of Glutose 15 stored on the same shelf with lubricating jelly, triple antibiotic ointment, and finger stick lancets. One box of eight vials of Atrovent for inhalation with an expiration date of 12/2008. An LPN was interviewed and confirmed that the oral medications were not to be stored with topical medications. She stated that the expired medications should have been removed and destroyed.	F 431		